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IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Epidural Steroid Injection Left L4-L5

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

This reviewer is a Board Certified Physical Medicine and Rehabilitation Doctor with over 20 years of experience.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who reported injury on XX/XX/XX when she was working. She was trying to put a stack of packaged paper up high on a shelf. They had a plastic wrap around them that started to come undone. They all started to slide and fall and she had to twist and jerk suddenly to catch them, and she felt a severe catch and pain in her back.

12/06/2013: Office Visit. **HPI:** Patient presents for evaluation of low back injury. She has continued to work but has continued to have severe pain and spasms in her back, a very significant stiffness that makes it difficult for her to move, bend or change positions. She has had trouble sleeping and has had some pain down her left leg as well. **Past Medical History:** Significant for hypertension, tachycardia, endometriosis, polycystic ovarian syndrome and spondylolisthesis at L5-S1 treated with surgery. **Examination:** She has severe muscular guarding and spasms in the mid to lower lumbar region with virtually no flexion or extension. Side bending is also severely limited and painful. Straight leg raise is painful on the left at 60°. Reflexes are intact in both lower extremities and equal. Plain films from on 11/27/13 show intact posterior fusion at L5 and S1 with interpeduncular screws and a disc cage without any change in hardware. Other than that, no acute fracture was seen. **Assessment:** Acute lumbago and lumbar sprain with some radicular features. **Plan:** If she does not improve or if she has pain radiating down her leg, we may order MRI. I think we can continue her on some pain medications and muscle relaxers, heat and muscle rubs like Icy Hot. I am prescribing a lumbar support to help support her and relieve the muscle. She may

continue working if she wants to but I would just have her avoid bending, stopping, twisting and overhead reaching and heavy lifting. Follow-up in 2 weeks.

12/19/2013: Office Visit. **HPI:** Patient does not feel that conservative treatment is working. She has significant pain with some radiation down her left leg. The questionnaire and the examination of this patient is difficult due to the fact that she had neurological compromise of her left leg after the surgery. **Exam:** Significant weakness of the dorsiflexors of the left foot. She is unable to perform bilateral straight leg raising. Reflexes are present, symmetrical and brisk and straight leg raising is negative bilaterally. **Plan:** The patient presents therefore with signs of an L4-L5 radiculopathy on the left side which is not explained by the previous surgery at L5-S1 and I recommend a CT myelogram of the lumbar spine. Off work, avoid prolonged sitting positions.

01/10/2014: CT Lumbar Myelogram interpreted by. **Impression:** 1. Posterior lateral L5-S1 fixation with probable artificial disc spacer. Right L5 pedicle screw extends beyond the anterior cortex and contacts the right common iliac vein. 2. Mild transverse canal narrowing at L5-S1 due to facet hypertrophy. Potential compromise of the descending left L5 nerve root. Questionable right foraminal disc extrusion which could compromise the right L4 nerve root. Consider MRI to confirm.

01/10/2014: Lumbar myelogram interpreted by. **Impression:** Unremarkable limited lumbar myelogram

02/06/2014: Office Visit. **HPI:** Ms. has been seen by and he recommends epidural steroid injection at L5-S1. The report does not express clearly what happens to this too long screw, but the patient states expresses no concern regarding this abnormality. **Diagnosis:** Radiculopathy L4-5 **Plan:** I have scheduled the pt for ESI. According to the results of the MRI, it seems that a possible compression is present not only at L5-S1 but also at L4-5 on the left side. I have therefore scheduled this patient for ESI at L4-5 and L5-S1 on the left side.

02/26/2014: Operative Report-Epidural Steroid Injection at levels L4-5, L5-S1 Bilateral

03/06/2014: Office Visit. **HPI** has not improved following the ESI on 2/26/14. At this point I believe that the patient should be reassessed for possible surgery and a reassessment by has been discussed. **Diagnosis:** Radiculopathy L4-5 **Plan:** Reassess in 3 weeks.

04/17/2014: Office Visit. **HPI:** Patient presents with pain in the low back. **Current Meds:** Norco 5-325 mg tabs, Zanaflex 4 mg tabs, Norco 5-325 tabs, Cyclobensaprine HCL 10 mg tabs, Norco tabs, Flexeril, Atenolol tabs **Subjective:** Ms. X returns today after having had multiple ESI's. She found that they were of little to no benefit. She is currently rating her pain as a 7/10. **Exam:** She stands from a seated position with moderate difficulty. She walks with a left-sided antalgic gait. Palpation of her lumbosacral junction demonstrates paraspinal muscular spasm. Left lateral bending continues to be her provocative movement. Left anterior tibialis, EHL are rated at 4/5 with the left quadriceps pain, rated a 4+/5. Light touch sensation intact and symmetric from L1-S1. **Impression:** UNS MECH Comp lint orthopedic device implant & graft, herniated lumbosacral disc failed back syndrome, back pain, lumbar with radiculopathy back pain. **Plan:** I do not feel her prominent pedicle screw is related to her current symptoms. I recommended an L4-5 laminectomy. The patient wants operative intervention.

06/05/2014: Letter of withdrawal as treating physician had more than 200 tabs of hydrocodone in 1 month per the pharmacist of xxxxx. I have advised the pharmacist that I withdrew from the care of the patient who is now under the care of. No prescription of hydrocodone for this patient will be issued from this office.

06/17/2014: Operative Report. **Pre-op Diagnosis:** 1. Lumbar herniated nucleus pulposus at L4-5, 2. Lumbar radiculopathy, 3. Back Pain. **Procedure:** 1. Laminectomy with bilateral medial facetectomies, bilateral foraminotomies and partial discectomy on the left.

06/17/2014: L-Spine 2-3 Views. **Impression:** 3 spot fluoroscopic images of the lumbar spine demonstrate prior posterior lumbar fusion at L5 and S1.

07/14/2014: Millennium UDT Radar Report. Medications found to be consistent with those reported.

07/14/2014: WC Extended Follow-up. The patient is doing well, pain is 5/10. Since the claimant had surgery on 6/17/14 and is now about five weeks out from the surgery itself, the weaning of opiate medications would be indicated at this point. The claimant should be weaning off of medications over the next month or so under the care of somebody familiar with weaning of medications.

07/24/2014: Office Visit. **HPI:** Ms X returns a bit early for her medication refill visit. She contacted us a couple of days ago and told us that she was getting low on her hydrocodone and that she wanted a refill. Our system showed that she was not supposed to be taking more than 10 tabs a day, but somehow the pharmacy deleted that from her prescription. She has shown me the bottle from the exact same prescription date and it indeed does not show not to exceed 10 a day labeling. We did a DPS search on the patient as well and there are no active prescribers after our date of first involvement in her care. She did get some pain meds roughly a week before she came to see us, however. It appears that what has happened here is that the pharmacy has failed to translate the exact prescription on to the prescription bottle. My staff will be contacting her pharmacy and telling them that the prescription label needs to be printed with respect to daily limits on the number of tabs they can take exactly as we write it. **Exam:** RLE: full strength, SLR neg LLE: EHL 1/5, quadriceps 4/5, SLR pos. Neurological: Reflexes: Patellar both 2/2, Achilles not elicited bilaterally, no clonus at the ankles Sensation: decreased left lateral calf and small toe. **Plan:** Updated Medicine List: Norco 7.5-325 mg tabs (hydrocodone-acetaminophen) 1-2 po q 4 hrs, NTE 10/day. Lyrica 50 mg caps (Pregabalin) 1 po bid, zanaflex 4 mg caps (Tizanidine HCL) prn; Rx's by other MD (non CPR physician) Atenolol 50 mg tabs (Atenolol) Qd

07/28/2014: Office Visit. **HPI:** Patient presented to the office today for completion of a random urine drug screen as requested. **Assessment:** Assessed WC1 back pain as unchanged, Assessed opioid type dependence continuous as unchanged.

09/24/2014: Office Visit. **HPI:** Back pain is moderate. Pain is in lower back, gluteal area and right flank. Pain is radiated to the dermatome anteriorly, left calf, left foot and left thigh. Symptoms are relieved by pain meds. Pt gets good relief from Percocet for 5 hours without side effects. Pt noticed pain relief with first dose of Neurontin. She has been having diarrhea for 1 week. **Impression/Plan:** Will increase Percocet to 4 per day, disp 120, no refills today. Pt will continue to increase Neurontin as directed to 900mg/day. Will refill tizanidine at night. UDS is consistent. Pt will fax in CT myelogram results and discussed possible injections. Pt. will start PT when cleared by surgeon. PT will RTO in 1 month.

12/29/2014: CT Spine Lumbar w/ contrast interpreted by. **Impression:** Postsurgical changes are present. There is no canal stenosis or foraminal narrowing seen on this examination.

01/08/2015: Office Visit. **HPI:** Follow-up CT myelogram **Subjective:** Ms. has apparently had a disagreement with her pain management physician and he let her go. Her pain is 10/10. She is taking oxycodone 10 mg q 4 hours, gabapentin 300mg in the afternoon and evening, and 900 mg at time of bed. She continues to experience radicular pain along L4-5 distribution with radiation to her right hip region. She is rating her pain today as 5/10. She states that is requesting a myelogram to plan injections. I am in agreement with this plan. **Exam:** Right sided antalgic gait. There is no pain to palpation in the midline from the occiput to thoracic region. Pain to palpation in the lumbosacrum region. There is notable paraspinal muscle spasm of the lumbosacral junction. Her wound is found to be healed. Lumbar spine: Full motor tstrength of bilateral lower extremities including hop flexion, hip extension, abduction, hamstrings, gastrocsoleus, anterior tibialis, extensor halluces longus and peroneals. 4/5 right quadriceps strength. Light touch sensation intact and symmetric from L1-S1. Positive straight leg raise. **Plan:** I will fill her pain meds until she can find a new physician. Referred to PT, and work on home exercise. If symptoms do not improve, and MRI of the lumbar spine will be necessary.

03/06/2015: Office Visit. **HPI:** Patient is here for med refills and follow-up . She is currently waiting for WC approval for injections. attempted an ESI. She states that she developed a post dural puncture headache that was treated conservatively. In Feb/March of 2014 a CT myelogram was performed. She underwent a

laminectomy/discectomy on 6/17/14. Despite these interventions the pt continues to have back pain with radiation to the right hip and left foot. **Exam:** Musculoskeletal: Inspection and palpation: Tenderness- moderate and over spinal column (lumbar incision x's2) Assessment of pain: Moderate and pain increases with sustained postures. Straight leg raising test positive. Lower extremity: Right: hip and flexors: 5/5. Left: hip flexors- 5/5 Functional testing: right: Patrick Test positive Left: Patrick test positive. **Assessment/Plan:** Continue Percocet, changed gabapentin 300mg 2 capsule every 8 hours as needed. Changed Zanaflex, 4 mg 1 tab every 12 hours.

04/06/2015: Electromyography Report-Bilateral Lower Extremity. **Current Chief Complaints:** Low back pain, left hip pain. Motor sensory: Numbness-down left leg to foot, Pins/needles-down left leg to foot, Tingling-down left leg to foot, Burning-lower back, Weakness-down left leg to foot. Pain scale: today-4-5, lowest-3, highest-9-10. Activities that increase pain: sitting, pushing, lifting, weather changes, standing, walking, carrying, bending. Decrease pain: exercise, cold packs, medication, rest, hot packs **Examination:** Lower extremity: Deep tendon reflexes-patellar: left 2, right 2. Achilles: left 2, right 2. Myotome testing: hip flexors- left 4/5, right 4/5. Leg extensors- left 4/5, right 5/5. Hip extensors-left 4/5, right 4/5. Leg flexors-left 4/5, right 5/5. ankle dorsiflexion-left 4/5, right 5/5. Ankle plantarflexion-left 4/5, right 5/5. **Impression:** There is no evidence of lumbar spine radiculopathy or neuropathy of the lower extremities.

08/10/2015: CT of the Cervical Spine post myelogram. **Impression:** 1. Fluoroscopic guided myelogram via the L2-L3 approach. 2. No myelographic block of contrast or significant truncation of nerve root sleeves. Please correlate with post myelogram CT for further characterization. **CT of the cervical spine post myelogram: Impression:** 1. Spondylosis most pronounced at the C4-C5 level with moderate central canal stenosis and moderate to severe foraminal narrowing worse on the right. 2. There is also mild spondylosis at C5-C6 contributing to mild to moderate foraminal narrowing. There is no significant canal stenosis. 3. There are likely small disc protrusions minimally indenting ventral surface of the thecal sac at the C2-C3 and C3-C4 levels without canal stenosis.

08/25/2015: Office Visit. **HPI:** Patient states she has a CT myelogram on 8/10/15 and was prescribed Zofran and Zanax. Pt reports ER visit due to spinal headaches 3 days after the myelogram. The headaches are slowly getting better, but her back pain is worsening. Patient would like to resubmit order for injection. **Exam:** Musculoskeletal: muscle strength and tone-good Gait: normal. Lumbosacral spine: no known fractures or deformities. Inspection and palpation: Tenderness-moderate, medial low back and over spinal column. Functional Testing-Straight leg raising test positive (left leg). Quadrant test negative. Moderate tenderness over Si joint r and l. Lower extremity: Patrick test positive. **Assessment/Plan:** Left L4/L5 ESI of anesthetic or steroid.

10/14/2015: Office Visit. **HPI:** Pt complains of low back pain with numbness/tingling and weakness into the left leg. Pain is described as 5/10, deep, burning, shooting, stabbing and pins and needles. Pain worsens with sitting, standing, walking, bending and lying down. Pain improves with heat/ice, medication, and lying down with her knees bent. Ms. X has a history of low back problems which resolved after a lumbar fusion in 2007. She was doing well until the. Following the injury she completed a course of PT without benefit. She underwent an ESI with no relief. Medications do not provide long term relief. **Exam:** Neurological-Reflexes: DTRs equal and symmetrical throughout, biceps reflex 2, triceps reflex 2, brachloradialis reflex 2, knee reflex 2, ankle reflex 2. Sensation: light touch: left L5 S1 dermatomal distribution sensation reduced to light touch. Musculoskeletal: Spine: Inspection/palpation: spinous process tender to palpation L5, no facet tenderness, no pain with facet loading, left straight leg raise test positive, well healed scar. Spine ROM normal, lumbar pain with flexion. **Assessment:** Back pain with radiation, displacement of thoracic or lumbar intervertebral disc without myelopathy; lumbar intervertebral disc without myelopathy, chronic pain syndrome, post-laminectomy syndrome; lumbar region. **Plan:** I will proceed with a left transforaminal ESI at L4, L5.

10/26/2015: UR. **Rationale for Denial:** The clinical information submitted for review fails to meet the evidence based guidelines for the requested service. Her current medications include gabapentin 300 mg, oxycodone 15 mg, and Zanaflex 4mg. Pertinent surgical history included a lumbar fusion in 2007. Diagnostic studies include an official lumbar CT performed on 8/10/15, which revealed spondylosis of facet, arthrosis at the L4-5 with lateral recess narrowing and displacement with impingement of traversing bilateral L5 nerve root sleeves. There was also mild central canal stenosis and moderate to severe foraminal narrowing, worse on the left. Other therapies

were noted to include heat/cold treatment, ESI in 2014, and physical therapy. On 10/14/15, the patient presented for an initial evaluation with low back pain complaints rated 5/10. The physical examination of the lumbar spine revealed tenderness to the spinous process. There was lack of tenderness to the facet with no pain upon facet loading. Patient had a positive straight leg raise on the left. ROM was noted to be normal. Patient had negative Patrick's sign bilaterally. Strength and reflexes was noted to be within normal values. Sensation was noted to be decreased at the L5-S1 dermatome. A request was received for epidural steroid injection to the L4-5. Her diagnosis include other intervertebral disc displacement of the lumbar region. According to the ODG, the criteria for epidural steroid repeat injections include documented objective pain relief, decreased need for medication, and improved functional response for at least 6-8 weeks. The patient was noted to have undergone a previous ESI in 2014. However, there was lack of clinical documentation in regard to the previous ESI to include a specific level and positive response of at least 50-0% pain relief, objective functional improvement, and reduction of pain medications for at least 6-8 weeks to warrant a repeat injection. Therefore, clarification is needed in regard to her previous ESI history and physical examination findings indicating neurological deficits at the L5-S1 and not at the L4-5 level as per the request. As such, the request is non –certified.

11/04/2015: UR. **Rationale for Denial:** The patient has been recommended for an ESI to the left at L4-5. This includes fluoroscopy. This is an appeal of a prior denial in which the previous reviewer opined that there was a lack of documentation regarding response to prior ESI to include a specific level and a positive response between 50-70% relief as well as an objective functional improvement and reduction of pain medications for at least 6-8 weeks. There was also further concern regarding inconsistent physical examination findings that found neurological deficits at L5-S1 and not at L4-5 level. The patient had been followed for complaints of low back pain radiating to the left lower extremity when she twisted her back on the date of injury. This had not improved after physical therapy and several medications to include muscle relaxants, anti-inflammatories, anticonvulsants, and narcotic medications. Recent CT myelogram studies of the lumbar spine from 8/10/15 noted diffused annular bulging at L4-5 measuring 2-3 mm with moderate to severe facet arthropahty. There was moderate right and severe left foraminal stenosis as well as mild lateral recess stenosis. There was impingement and displacement of the traversing bilateral L5 nerve roots. A prior lumbar spinal fusion procedure anterior to posterior was noted at L5-S1. There was minimal attenuation of the traversing S1 nerve root sleeves and likely contact of the exiting bilateral L5 nerve root sleeves. The 10/14/15 evaluation noted that prior ESI's in 2014 provided no relief. The patient's physical examination noted intact strength in the lower extremities with 2+ and symmetric reflexes. There was sensory loss noted in a left L5-S1 distribution. Tenderness was present over the L5 region with positive straight leg raise signs to the left. There were concerns present over the L5 region with positive straight leg raise signs to the left. There were concerns regarding the amount of Oxycodone being utilized by the patient. There again was a recommendation for a transforaminal ESI at L4-5. The additional clinical documentation submitted for review did not address the prior reviewer's concerns. It is unclear at what levels prior ESI were attempted at. It is noted that the patient had no prior response to ESI's. Guidelines do not recommend repeat ESI's in patients who do not respond to initial injections. The patient's CT myelogram study did note encroachment of the L5 nerve roots at both L4-5 and L5-S1. Without further information regarding the patient's response to prior ESI's and the rationale for continuing epidurals when prior injections were unsuccessful, this request cannot be certified.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The denial of Epidural Steroid Injection Left L4-L5 is UPHELD/AGREED UPON since there is documentation of successful response to previous ESI's.

Criteria for the use of Epidural steroid injections:
Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, reduction of medication use and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.
(1) Radiculopathy (due to herniated nucleus pulposus, but not spinal stenosis) must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing.

(2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs, muscle relaxants & neuropathic drugs).
(3) Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance.
(4) *Diagnostic Phase:* At the time of initial use of an ESI (formally referred to as the "diagnostic phase" as initial injections indicate whether success will be obtained with this treatment intervention), a maximum of one to two injections should be performed. A repeat block is not recommended if there is inadequate response to the first block (< 30% is a standard placebo response). A second block is also not indicated if the first block is accurately placed unless: (a) there is a question of the pain generator; (b) there was possibility of inaccurate placement; or (c) there is evidence of multilevel pathology. In these cases a different level or approach might be proposed. There should be an interval of at least one to two weeks between injections.
(5) No more than two nerve root levels should be injected using transforaminal blocks.
(6) No more than one interlaminar level should be injected at one session.
(7) *Therapeutic phase:* If after the initial block/blocks are given (see "Diagnostic Phase" above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported. This is generally referred to as the "therapeutic phase." Indications for repeat blocks include acute exacerbation of pain, or new onset of radicular symptoms. The general consensus recommendation is for no more than 4 blocks per region per year. (CMS, 2004) (Boswell, 2007)
(8) Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response.
(9) Current research does not support a routine use of a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections for the initial phase and rarely more than 2 for therapeutic treatment.
(10) It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or sacroiliac blocks or lumbar sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment.
(11) Cervical and lumbar epidural steroid injection should not be performed on the same day. (Doing both injections on the same day could result in an excessive dose of steroids, which can be dangerous, and not worth the risk for a treatment that has no long-term benefit.)

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**